



Key Info on Sepsis and COVID-19

Sepsis +SARS-CoV-2 vs. Sepsis +Other

Sepsis **may complicate** COVID-19 or occur in patients incidentally colonised with SARS-CoV-2. It is often **difficult to distinguish clinically** between severe COVID-19 (+/- sepsis) and sepsis due to other infections

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- Screen all patients for sepsis with elevated early warning scores or who deteriorate during admission
- Collect blood (>10ml/bottle), sputum for microbiology and virology and other investigations (e.g. a urine culture if urinary tract infection is suspected or wound swab if skin / soft tissue infection)

Review after 24-72h

on the basis of **microbiology results** and **clinical judgement**

Antimicrobial prescribing for suspected and confirmed COVID-19

CRP

A raised C-reactive protein and fever are commonly present and do not predict bacterial co-infection.

Antibiotic over-use

Overuse of antibiotics leads to antimicrobial resistance, Clostridium difficile infection, threatens stocks of antimicrobial supplies and exposes colleagues administering these drugs to increased risk of infection with SARS-2-CoV.

Community COVID-19

For patients presenting from the community with suspected COVID-19 pneumonia (infiltrates on CXR), please calculate the CURB65 score and follow Trust guidelines on empirical antimicrobial prescribing

Hospital-acquired pneumonia

SARS-CoV-2 positive patients with hospital acquired pneumonia (or infective exacerbation of COPD) should be treated as per the respective clinical syndromes and Trust antimicrobial guidelines

Prescriptions

The antibiotic prescription should be reviewed daily in light of the clinical progress and the culture results; please consider iv to oral switch when clinical status allows and the enteral route of administration is secure (patient should be eating and drinking, not vomiting, with a safe swallow or NG tube in situ).

Stopping antibiotics

For patients in whom COVID-19 infection is confirmed and there are no indications of a secondary bacterial infection, **stopping empirical antibiotics** early should be considered.

CURB65 score:

1 point for each of the following prognostic features:

- Confusion (abbreviated Mental Test score 8 or less, or new disorientation in person, place or time)
- Urea > 7 mmol/litre
- Respiratory rate ≥30 breaths per minute
- Blood pressure (diastolic ≤ 60 mmHg or systolic < 90 mmHg)
- Age ≥ 65 years

CURB65 Score	Antibiotics	
	1st choice	Penicillin allergy
0-1	Amoxicillin PO 500mg-1g TDS for 5 days	Doxycycline 200mg stat, followed by 100mg OD (total course 5 days)
2	Amoxicillin PO 1g TDS and clarithromycin 500mg BD for 7 days	Levofloxacin PO 500mg OD for 7 days
3-5	Amoxicillin IV 1g TDS and levofloxacin 500mg OD IV* for 7 days	Levofloxacin IV* 500mg BD for 7 days

*consider switch to PO after 24-72hours if appropriate to do so. Please use PO moxifloxacin 400mg OD in place of levofloxacin for oral switch.